**191—37.11 (514D) Medicare Select policies and certificates.**

**37.11(1)** *a.* Rule 191—37.11(514D) shall apply to Medicare Select policies and certificates, as defined in this rule.

*b.* No policy or certificate may be advertised as a Medicare Select policy or certificate unless it meets the requirements of this rule.

**37.11(2)** For the purposes of this rule:

*a.* *"Complaint"* means any dissatisfaction expressed by an individual concerning a Medicare Select issuer or its network providers.

*b.* *"Grievance"* means dissatisfaction expressed in writing by an individual insured under a Medicare Select policy or certificate with the administration, claims practices, or provision of services concerning a Medicare Select issuer or its network providers.

*c.* *"Medicare Select Issuer"* means an issuer offering, or seeking to offer, a Medicare Select policy or certificate.

*d.* *"Medicare Select Policy"* or *"Medicare Select Certificate"* means respectively, a Medicare supplement policy or certificate that contains restricted network provisions.

*e.* *"Network Provider"* means a provider of health care, or a group of providers of health care, which has entered into a written agreement with the issuer to provide benefits insured under a Medicare Select policy.

*f.* *"Restricted Network Provision"* means any provision which conditions the payment of benefits, in whole or in part, on the use of network providers.

*g.* *"Service Area"* means the geographic area approved by the commissioner within which an issuer is authorized to offer a Medicare Select policy.

**37.11(3)** The commissioner may authorize an issuer to offer a Medicare Select policy or certificate, pursuant to this rule and Section 4358 of the Omnibus Budget Reconciliation Act (OBRA) of 1990, if the commissioner finds that the issuer has satisfied all of the requirements.

**37.11(4)** A Medicare Select issuer shall not issue a Medicare Select policy or certificate in this state until its plan of operation has been approved by the commissioner.

**37.11(5)** A Medicare Select issuer shall file a proposed plan of operation with the commissioner in a format prescribed by the commissioner. The plan of operation shall contain at least the following information:

*a.* Evidence that all covered services that are subject to restricted network provisions are available and accessible through network providers, including a demonstration that:

(1) Such services can be provided by network providers with reasonable promptness with respect to geographic location, hours of operation and after-hour care. The hours of operation and availability of after-hour care shall reflect usual practice in the local area. Geographic availability shall reflect the usual travel times within the community.

(2) The number of network providers in the service area is sufficient, with respect to current and expected policyholders, either:

1. To adequately deliver all services that are subject to a restricted network provision; or
2. To make appropriate referrals.

(3) There are written agreements with network providers describing specific responsibilities.

(4) Emergency care is available 24 hours per day and seven days per week.

(5) In the case of covered services that are subject to a restricted network provision and are provided on a prepaid basis, there are written agreements with network providers prohibiting such providers from billing or otherwise seeking reimbursement from or recourse against any individual insured under a Medicare Select policy or certificate. This paragraph shall not apply to supplemental charges or coinsurance amounts as stated in the Medicare Select policy or certificate.

*b.* A statement or map providing a clear description of the service area.

*c.* A description of the grievance procedure to be utilized.

*d.* A description of the quality assurance program, including:

(1) The formal organizational structure;

(2) The written criteria for selection, retention and removal of network providers; and

(3) The procedures for evaluating quality of care provided by network providers, and the process to initiate corrective action when warranted.

*e.* A list and description, by specialty, of the network providers.

*f.* Copies of the written information proposed to be used by the issuer to comply with 37.11(9).

*g.* Any other information requested by the commissioner.

**37.11(6)** *a.* A Medicare Select issuer shall file any proposed changes to the plan of operation, except for changes to the list of network providers, with the commissioner prior to implementing such changes. Such changes shall be considered approved by the commissioner after 30 days unless specifically disapproved.

*b.* An updated list of network providers shall be filed with the commissioner at least quarterly.

**37.11(7)** A Medicare Select policy or certificate shall not restrict payment for covered services provided by nonnetwork providers if:

*a.* The services are for symptoms requiring emergency care or are immediately required for an unforeseen illness, injury or a condition; and

*b.* It is not reasonable to obtain such services through a network provider.

**37.11(8)** A Medicare Select policy or certificate shall provide payment for full coverage under the policy for covered services that are not available through network providers.

**37.11(9)** A Medicare Select issuer shall make full and fair disclosure in writing of the provisions, restrictions, and limitations of the Medicare Select policy or certificate to each applicant. This disclosure shall include at least the following:

*a.* An outline of coverage sufficient to permit the applicant to compare the coverage and premiums of the Medicare Select policy or certificate with:

(1) Other Medicare supplement policies or certificates offered by the issuer; and

(2) Other Medicare Select policies or certificates.

*b.* A description (including address, telephone number and hours of operation) of the network providers, including primary care physicians, specialty physicians, hospitals and other providers.

*c.* A description of the restricted network provisions, including payments for coinsurance and deductibles, when providers other than network providers are utilized. Except to the extent specified in the policy or certificate, expenses incurred when using out-of-network providers do not count toward the out-of-pocket annual limit contained in plans "K" and "L."

*d.* A description of coverage for emergency and urgently needed care and other out-of-service area coverage.

*e.* A description of limitations on referrals to restricted network providers and to other providers.

*f.* A description of the policyholder's rights to purchase any other Medicare supplement policy or certificate otherwise offered by the issuer.

*g.* A description of the Medicare Select issuer's quality assurance program and grievance procedure.

**37.11(10)** Prior to the sale of a Medicare Select policy or certificate, a Medicare Select issuer shall obtain from the applicant a signed and dated form stating that the applicant has received the information provided pursuant to 37.11(9) and that the applicant understands the restrictions of the Medicare Select policy or certificate.

**37.11(11)** A Medicare Select issuer shall have and use procedures for hearing complaints and resolving written grievances from the subscribers. Such procedures shall be aimed at mutual agreement for settlement and may include arbitration procedures.

*a.* The grievance procedure shall be described in the policy and certificates and in the outline of coverage.

*b.* At the time the policy or certificate is issued, the issuer shall provide detailed information to the policyholder describing how a grievance may be registered with the issuer.

*c.* Grievances shall be considered in a timely manner and shall be transmitted to appropriate decision makers who have authority to fully investigate the issue and take corrective action.

*d.* If a grievance is found to be valid, corrective action shall be taken promptly.

*e.* All concerned parties shall be notified about the results of a grievance.

*f.* The issuer shall report no later than each March 31 to the commissioner regarding its grievance procedure. The report shall be in a format prescribed by the commissioner and shall contain the number of grievances filed in the past year and a summary of the subject, nature and resolution of such grievances.

**37.11(12)** At the time of initial purchase, a Medicare Select issuer shall make available to each applicant for a Medicare Select policy or certificate the opportunity to purchase any Medicare supplement policy or certificate otherwise offered by the issuer.

**37.11(13)** *a.* At the request of an individual insured under a Medicare Select policy or certificate, a Medicare Select issuer shall make available to the individual insured the opportunity to purchase a Medicare supplement policy or certificate offered by the issuer which has comparable or lesser benefits and which does not contain a restricted network provision. The issuer shall make such policies or certificates available without requiring evidence of insurability after the Medicare Select policy or certificate has been in force for six months.

*b.* For the purposes of this subrule, a Medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one or more significant benefits not included in the Medicare Select policy or certificate being replaced. For the purposes of this paragraph, a significant benefit means coverage for the Medicare Part A deductible, coverage for at-home recovery services or coverage for Part B excess charges.

**37.11(14)** Medicare Select policies and certificates shall provide for continuation of coverage in the event the Secretary of Health and Human Services determines that Medicare Select policies and certificates issued pursuant to this section should be discontinued due to either the failure of the Medicare Select program to be reauthorized under law or its substantial amendment.

*a.* Each Medicare Select issuer shall make available to each individual insured under a Medicare Select policy or certificate the opportunity to purchase any Medicare supplement policy or certificate offered by the issuer which has comparable or lesser benefits and which does not contain a restricted network provision. The issuer shall make such policies and certificates available without requiring evidence of insurability.

*b.* For the purposes of this subrule, a Medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one or more significant benefits not included in the Medicare Select policy or certificate being replaced. For the purposes of this paragraph, a significant benefit means coverage for the Medicare Part A deductible, coverage for at-home recovery services or coverage for Part B excess charges.

**37.11(15)** A Medicare Select issuer shall comply with reasonable requests for data made by state or federal agencies, including the United States Department of Health and Human Services, for the purpose of evaluating the Medicare Select program.

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